FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022996

Facility Name: Iona Glos SLC

Address: 50 S. Fairbanks (Number) Addison (City) 60101 (Zip Code)

County: DuPage

Telephone Number: (630) 620-2222 **Fax #** (630) 628-1488

IDPA ID Number: 36-2411166-001

Date of Initial License for Current Owners: November 18, 1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	E9982-6984-02		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kathleen Francis **Telephone Number:** (630) 620-2222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2001 to 06/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) John Budzynski
(Title) Chief Financial \Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds no change

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	35,602			35,602	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,602			35,602	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.54%

D. How many bed-hold days during this year were paid by Public Aid?
898 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11 / 18 / 80

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/ Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	151,509		10,270	161,779		161,779		161,779			1
2	Food Purchase		246,281		246,281		246,281		246,281			2
3	Housekeeping		80,224	59,765	139,989		139,989	(11)	139,978			3
4	Laundry											4
5	Heat and Other Utilities			114,425	114,425		114,425	(109)	114,316			5
6	Maintenance	42,859	49,721		92,580		92,580	(13)	92,567			6
7	Other (specify):* waste removal			14,073	14,073		14,073		14,073			7
8	**TOTAL General Services**	194,368	376,226	198,533	769,127		769,127	(133)	768,994			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	601,946	60,142	118,592	780,680		780,680		780,680			10
10a	Therapy	1,711,682		43,575	1,755,257		1,755,257		1,755,257			10a
11	Activities	32,519	11,360		43,879		43,879		43,879			11
12	Social Services	9,913			9,913		9,913		9,913			12
13	Nurse Aide Training	26,937	615		27,552		27,552		27,552			13
14	Program Transportation	110,614		26,714	137,328	441	137,769		137,769			14
15	Other (specify):* lic/cert & sch XVIII	(68,253)	2,076	31,072	(35,105)		(35,105)		(35,105)			15
16	**TOTAL Health Care and Programs**	2,425,358	74,193	219,953	2,719,504	441	2,719,945		2,719,945			16
	C. General Administration											
17	Administrative	442,363			442,363		442,363	(28,154)	414,209			17
18	Directors Fees											18
19	Professional Services			53,230	53,230	(2,721)	50,509	(18,444)	32,065			19
20	Dues, Fees, Subscriptions & Promotions			14,687	14,687		14,687	(973)	13,714			20
21	Clerical & General Office Expenses	346,750	68,096		414,846	412	415,258	(9,089)	406,169			21
22	Employee Benefits & Payroll Taxes			577,218	577,218	2,500	579,718	(5,992)	573,726			22
23	Inservice Training & Education			2,688	2,688	13	2,701	(23)	2,678			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			3,164	3,164		3,164	(1,165)	1,999			25
26	Insurance-Prop.Liab.Malpractice			58,116	58,116		58,116	(219)	57,897			26
27	Other (specify):* worksheet 3			18,511	18,511	(204)	18,307	(9,007)	9,300			27
28	**TOTAL General Administration**	789,113	68,096	727,614	1,584,823		1,584,823	(73,066)	1,511,757			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,408,839	518,515	1,146,100	5,073,454	441	5,073,895	(73,199)	5,000,696			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Iona Glos SLC #0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			95,969	95,969		95,969	150,427	246,396			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,516	14,516		14,516	(535)	13,981			32
33	Real Estate Taxes			1,011	1,011		1,011		1,011			33
34	Rent-Facility & Grounds			72,771	72,771	(874)	71,897	(5,614)	66,283			34
35	Rent-Equipment & Vehicles			41,722	41,722	433	42,155	(8,496)	33,659			35
36	Other (specify):*											36
37	**TOTAL Ownership**			225,989	225,989	(441)	225,548	135,782	361,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			11,694	11,694		11,694		11,694			41
42	Provider Participation Fee			310,692	310,692		310,692		310,692			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			322,386	322,386		322,386		322,386			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,408,839	518,515	1,694,475	5,621,829		5,621,829	62,583	5,684,412			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(535)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(451)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,050)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(51,101)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,137)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	117,719		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 117,719		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 62,582		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Iona Glos SLC

ID# 0022996

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjustment for Fundraising = 50 % of Public	$		1
2	Relations & Development - also see worksheet 1			2
3				3
4	Housekeeping Supplies	(11)	3	4
5	Utilities	(109)	5	5
6	Maintenance	(13)	6	6
7	Administrative	(26,293)	17	7
8	Professional Services	(283)	19	8
9	Publications	(675)	20	9
10	Membership Dues	(298)	20	10
11	Clerical & General Office	(9,089)	21	11
12	Employee Benefits & Payroll Taxes	(5,992)	22	12
13	Staff Training	(23)	23	13
14	Travel	(199)	25	14
15	Insurance	(219)	26	15
16	Agency Functions	(605)	27	16
17	Depreciation	(1,204)	30	17
18	Rent	(5,786)	34	18
19	Equipment Rental	(876)	35	19
20	Total Fund Raising Adjustment	(51,675)		20
21				21
22	Other Non-Allowables & Adjustments			22
23	Administrative Other Compensation	(1,861)	17	23
24	Non-Care Related Legal and Professionl Services	(18,161)	19	24
25	Non-Care Related Admin Staff Transportation	(966)	25	25
26	In & Out	(179)	27	26
27	Agency Functions	(4,722)	27	27
28	Depreciation Adjustments	28,545	30	28
29	Rent Adjustment	172	34	29
30	Non-Care Related Administrative Leased Vehicle	(2,253)	35	30
31	Total Other Non-Allowables & Adjustments	575		31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(102,200)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Iona Glos SLC # 0022996 **Report Period Beginning:** 07/01/2001 **Ending:** 06/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(11)	0	0	0	0	0	0	0	0	0	0	(11)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(109)	0	0	0	0	0	0	0	0	0	0	(109)	5
6	Maintenance	(13)	0	0	0	0	0	0	0	0	0	0	(13)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(133)	0	0	0	0	0	0	0	0	0	0	(133)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(28,154)	0	0	0	0	0	0	0	0	0	0	(28,154)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,444)	0	0	0	0	0	0	0	0	0	0	(18,444)	19
20	Fees, Subscriptions & Promotions	(973)	0	0	0	0	0	0	0	0	0	0	(973)	20
21	Clerical & General Office Expenses	(9,089)	0	0	0	0	0	0	0	0	0	0	(9,089)	21
22	Employee Benefits & Payroll Taxes	(5,992)	0	0	0	0	0	0	0	0	0	0	(5,992)	22
23	Inservice Training & Education	(23)	0	0	0	0	0	0	0	0	0	0	(23)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,165)	0	0	0	0	0	0	0	0	0	0	(1,165)	25
26	Insurance-Prop.Liab.Malpractice	(219)	0	0	0	0	0	0	0	0	0	0	(219)	26
27	Other (specify):*	(9,007)	0	0	0	0	0	0	0	0	0	0	(9,007)	27
28	**TOTAL General Administration**	(73,066)	0	0	0	0	0	0	0	0	0	0	(73,066)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(73,199)	0	0	0	0	0	0	0	0	0	0	(73,199)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Iona Glos SLC** **#** **0022996** **Report Period Beginning:** **07/01/2001** **Ending:** **06/30/2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	27,341	123,086	0	0	0	0	0	0	0	0	0	150,427	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(535)	0	0	0	0	0	0	0	0	0	0	(535)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(5,614)	0	0	0	0	0	0	0	0	0	0	(5,614)	34
35	Rent-Equipment & Vehicles	(3,129)	(5,367)	0	0	0	0	0	0	0	0	0	(8,496)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	18,063	117,719	0	0	0	0	0	0	0	0	0	135,782	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(55,136)	117,719	0	0	0	0	0	0	0	0	0	62,583	45

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Not for Profit Corp - board members DO NOT have ownership in the Ray Graham Association or the Ray Graham Foundation				Ray Graham Foundation	Downers Grove, IL	social service
see attached list of board of directors						foundation
no board members directly provided service to the SLC						
no board members have ownership in any entity that conducted buseness transactions with the SLC						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	building depreciation	$	Ray Graham Foundation Downers Grove, IL		$ 119,774	$ 119,774	1
2	V								2
3	V	30	equipment depreciation		Ray Graham Foundation Downers Grove, IL		3,312	3,312	3
4	V								4
5	V	35	vehicle lease	5,367	Ray Graham Foundation Downers Grove, IL			(5,367)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 5,367			$ 123,086	$ * 117,719	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	none										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Ray GrahamFoundation
Street Address: 2801 Finley Road
City / State / Zip Code: DownersGrove, IL 60532
Phone Number: (630) 620-2222
Fax Number: (630) 628-2350

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see worksheet 1				$ 2,579,065	$ 1,396,428		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,579,065	$ 1,396,428		$	25

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lucent/AVAYA Financial		X	Phone System - Admin	$967.00	7/1/97	$ 50,369	$	7/1/02	0.0560	$ 350	1
2	American National Bank		X	Computers - Admin	$757.00	12/24/98	24,176		12/30/01	0.0775	101	2
3	totals				$1,724.00		74,545				451	3
4	SLC allocation = .31				$534.44		23,109				140	4
5												5
	Working Capital											
6	allocated - see worksheet 6	X		operating funds			1,242,707	350,871			13,842	6
7	NOTE: COL 4 LINE 9 AMOUNT											7
8	WRONG DUE TO PROTECTION											8
9	TOTAL Facility Related				$3,982.44		$ 1,265,816	$ 350,871			$ 13,982	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,265,816	$ 350,871			$ 13,982	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1,952	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2,171	2
3. Under or (over) accrual (line 2 minus line 1).	$	219	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	792	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	1,011	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	305	8
1998	310	9
1999	886	10
2000	1,066	11
2001	1,105	12

line 2. 2000 bill = 1,066 plus 2001 bill = 1,105

line 4. 2002 estimated at 8.5% less than 2001 = 1,011; less prior yr adj = 219

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Iona Glos SLC COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0022996

CONTACT PERSON REGARDING THIS REPORT kathleen Francis

TELEPHONE (630) 620 - 2222 FAX #: (630) 628 - 1488

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-26-304-012	442 W. Fullerton, Elmhurst, IL	$ 27,904.88	$ 1,105.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,904.88	$ 1,105.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,000 B. General Construction Type: Exterior brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SLC		1990	$ 214,674	1
2					2
3	TOTALS			$ 214,674	3

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1981	1981	$ 3,681,931	$ 92,048	40	$ 92,048	$ (0)	$ 1,979,038	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Fiscal Years			1996	181,400	18,140	5	18,140		181,400	9
10				1997	223,702	22,540	3-5	22,540		223,532	10
11				1998	47,104	9,252	3-5	9,252		37,827	11
12				2001	841	280	3	280		421	12
13											13
14	fire hydrants & gate valves			2002	4,050	405	5	405		405	14
15	toilet			2002	547	55	5	55		55	15
16	carpeting in home #1			2002	3,696	370	5	370		370	16
17	window treatments in home #6			2002	6,118	612	5	612		612	17
18	replace closeets block walls			2002	2,800	280	5	280		280	18
19	steel door and door frame in home #1 kitchen			2002	850	85	5	85		85	19
20	fence - trraditinal western & red cedar			2002	2,690	269	5	269		269	20
21	roof repair			2002	4,200	420	5	420		420	21
22	shower bases repllaaacements (7)			2002	30,296	3,030	5	3,030		3,030	22
23	shower valves replacements (2)			2002	425	43	5	43		43	23
24	concreate sidewalk and patio replacements			2002	9,400	940	5	940		940	24
25											25
26	From Ray Graham Association Foundation										26
27	From Prior Fiscal Years			1999	59,303	7,050	5-10	7,050		24,674	27
28				2000	114,746	11,475	10	11,475		28,557	28
29				2001	78,312	7,831	10	7,831		11,747	29
30											30
31	home 5 interior doors replaced and walls repaired			2002	10,849	1,007	5	1,007		1,007	31
32	concrete walk repair			2002	6,400	320	10	320		320	32
33	steel door and door frame in home #5			2002	850	43	10	43		43	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fullerton Buiding Allocation		$	$		$	$	$	37
38	prior years		70,447	8,344	5-10	8,344		17,462	38
39									39
40	4 power-flush toilets installed	2002	1,532	153	5	153		153	40
41	total Fullerton		71,979	8,497		8,497		17,615	41
42	Transportation portion - .65%		468	55		55		115	42
43	Intake portion - .45%		324	39		39		80	43
44	Clinical portion - .25%		180	21		21		44	44
45	Administration portion - 12.64%		9,099	1,074		1,074		2,226	45
46	SLC portion of Trasnportation - 6.38%		30	3		3		7	46
47	SLC portion of Intake - 2.98%		9	1		1		2	47
48	SLC portion of Clinical - 4%		7	1		1		2	48
49	SLC portion of Administration - 32%		2,905	343		343		711	49
50	total SLC portion		2,951	348		348		722	50
51									51
52	Finley Building Allocation								52
53	office renovations including painting, carpeting,	2002	38,258	7,544	5	7,544		7,544	53
54	reconfiguration of offices (walls and doors moved), cabeling,								54
55	electrical re-routing, ceiling tile replacements,								55
56	water damage repairs								56
57	Administration portion - 32%		28,203	5,562		5,562		5,562	57
58	Intake portion - 2.98%		474	94		94		94	58
59	Clinical portion - 4.		1,526	301		301		301	59
60	SLC portion of Administration - 32%		8,916	1,759		1,596	(163)	1,596	60
61	SLC portion of Intake - 2.98%		14	3		3		3	61
62	SLC portion of Clinical - 4%		61	12		12		12	62
63	total SLC portion		8,991	1,774		1,611	(163)	1,611	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,482,453	$ 178,616		$ 178,453	$ (163)	$ 2,497,407	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,482,453	$ 178,616		$ 178,453	$ (163)	$ 2,497,407	1
2	REVERSE THE ABOVE BECAUSE THIS PAGE IS REALLY PAGE 13A		(4,482,453)	(178,616)		(178,453)	163	(2,497,407)	2
3	EQUIPMENT DEPRECIATION								3
4									4
5	Purchased in Prior Years								5
6	SLC		91,276	15,032	5	15,032		71,926	6
7	Transportation		4,386	877	5	877		1,318	7
8	Intake		103	21	3-5	21		33	8
9	Clinical		58	12	5	12		18	9
10	Administration		2,907	581	5	581		913	10
11	SLC portion of Transportation - 6%		280	56		56		84	11
12	SLC portion of Intake - 3%		3	1		1		1	12
13	SLC portion of Clinical - 4%		2					1	13
14	SLC portion of Administration - 32%		928	186		186		292	14
15									15
16	Current Year Purchases								16
17	SLC								17
18	office furniture, including credenza, desk, keyboard tray		985	99	5	99		99	18
19	scale, - beam, wheelchair with ramp, 350 lb capacity		1,394	139	5	139		139	19
20	reliant plus power ift		3,813	381	5	381		381	20
21	snow thrower - Toro Snow Commander E		860	86	5	86		86	21
22	six folding tables		828	83	5	83		83	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 100,369	$ 16,063		$ 16,063	$	$ 73,092	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 100,369	$ 16,063		$ 16,063	$	$ 73,092	1
2	THIS IS REALLY PAGE 13B - EQUIPMENT DEPRECIATION								2
3									3
4	Fullerton Building								4
5	conference tables and office chairs		1,113	111	5	111		111	5
6	2 refridgerators - 17 cu almond		1,137	114	5	114		114	6
7	total Fullerton		2,251	225		225		225	7
8	Transportation portion - .65%		15	1		1		1	8
9	Intake portion - .45%		10	1		1		1	9
10	Clinical portion - .25%		6	1		1		1	10
11	Administration portion - 12.64%		285	28		28		28	11
12	SLC portion of Trasnportation - 6.38%		1						12
13	SLC portion of Intake - 2.98%								13
14	SLC portion of Clinical - 4%								14
15	SLC portion of Administration - 32%		91	9		9		9	15
16	total SLC portion		92	9		9		9	16
17									17
18									18
19									19
20									20
21									21
22	Ray Graham Foundation -								22
23	Purchased in Prior Years								23
24	SLC		13,623	2,633		2,633		6,812	24
25	Administration		20,740	2,126		2,126		18,135	25
26	SLC portion - 32%		6,637	680		680		5,803	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 120,720	$ 19,386		$ 19,386	$	$ 85,715	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 120,720	$ 19,386		$ 19,386	$	$ 85,715	1
2	THIS IS REALLY PAGE 13C - EQUIPMENT DEPRECIATION								2
3	Management and General -								3
4	Purchased in Prior Years		357,880	84,541		84,541		153,252	4
5	SLC portion - 32%		114,522	27,053		26,012	(1,041)	49,041	5
6									6
7	Current Year Purchases								7
8	Dell PC (2)		2,154	215	5	215		215	8
9	Arm Chairs - Aubergines 10		1,045	105	5	105		105	9
10	Dell Computers - 2		5,180	2,639	2	2,639		2,639	10
11	Donated Norton antivirus 100 licenses		5,025	503	5	503		503	11
12	6 Dell Computers - Pentium III		5,520	552	5	552		552	12
13	Inspiration Lap Top computer		1,475	148	5	148		148	13
14	Monarch V6 Standard Edition		507	51	5	51		51	14
15	Fundware Miration to Enterprise		56,109	5,611	5	5,611		5,611	15
16	Notevision Sharp LCD projector		2,605	261	5	261		261	16
17	Firebox 700 Firewall		1,912	191	5	191		191	17
18	Back UpExec Windows (7) servers		3,622	362	5	362		362	18
19	Dell computer Software & Hardware		3,739	374	5	374		374	19
20	Dell servers & software		19,108	1,911	5	1,911		1,911	20
21	Scanner		477	48	5	48		48	21
22	Data Cabinets		4,139	414	5	414		414	22
23	current year total		112,616	13,383		13,383		13,383	23
24	SLC allocation - 32%		36,037	4,283		4,283		4,283	24
25									25
26	Fully Depricatied		108,472					108,472	26
27	SLC allocation - 32%		34,711					34,711	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 305,990	$ 50,722		$ 49,681	$ (1,041)	$ 173,750	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 227,270	$ 45,642	$ 44,601	$ (1,041)		$ 133,959	71
72	Current Year Purchases	44,009	5,079	5,079			5,079	72
73	Fully Depreciated Assets	34,711					34,711	73
74	also see pages 12B,12C,12D/13A,13B,13C							74
75	TOTALS	$ 305,990	$ 50,722	$ 49,681	$ (1,041)		$ 173,750	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	client transportation	1992 Ford Econoline	1995	$ 6,654	$	$	$		$ 6,654	76
77	client transportation	1997 Dodge MiniVan	1997	35,401	3,540	3,540			35,401	77
78	client transportation	1998 Dodge Van	1998	36,417	7,283	7,283			25,492	78
79	client transportation	1999 Dodge Van	1999	37,203	7,441	7,441				79
80	TOTALS			$ 115,675	$ 18,264	$ 18,264	$		$ 67,547	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,118,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 247,601	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 246,397	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,204)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,738,703	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: Stojka Brothers Partnership and Real Esate Opportunity Corp. and Midwest Surgical - see worksheet 7

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		n/a	10/15/98	$ 7,817	5	n/a	3
4	Additions		n/a	01/27/98	39,681	6	n/a	4
5			na	02/26/02	18,786		n/a	5
6								6
7	TOTAL				$ 66,284 **			7

10. Effective dates of current rental agreement:
Beginning 10/15/98&02/26/02
Ending 10/14/03&02/28/11

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	06/2003	$ 61,119
13.	06/2004	$ 62,216
14.	06/2005	$ 64,733

8. List separately any amortization of lease expense included on page 4, line 34. n/a
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 29,520 Description: worksheet 8
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	client transportation	PACE vehicle #1697	$ 345.00	$ 4,140	17
18					18
19					19
20					20
21	TOTAL		$ 345.00	$ 4,140	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	40
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	90
IN OTHER FACILITY	
HOURS PER AIDE	90

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		261	354		615
3	Classroom Wages	(a)		6,346		6,346
4	Clinical Wages	(b)	6,313	14,279		20,591
5	In-House Trainer Wages	(c)	1,034	3,461		4,495
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 7,607	$ 24,440	$	$ 32,047
10	SUM OF line 9, col. 1 and 2	(e)	$ 32,047			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	14
2. From other facilities (f)	
TOTAL TRAINED	33

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	none	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Iona Glos SLC **#** 0022996 **Report Period Beginning:** 07/01/2001 **Ending:** 06/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,715	$	1
2	Cash-Patient Deposits	126,213		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,775)	2,613,774		3
4	Supply Inventory (priced at cost)	26,352		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,044		6
7	Other Prepaid Expenses	9,800		7
8	Accounts Receivable (owners or related parties)	6,363		8
9	Other(specify): security deposits	34,340		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,871,601	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,844,906		15
16	Equipment, at Historical Cost	2,988,870		16
17	Accumulated Depreciation (book methods)	(3,818,678)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,015,098	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,886,699	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,919,128	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	126,213		28
29	Short-Term Notes Payable	9,091		29
30	Accrued Salaries Payable	890,627		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,254		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,730		32
33	Accrued Interest Payable			33
34	Deferred Compensation	66,709		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	capital lease obligatin	4,832		36
37	deferred ncome	40,786		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,113,370	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	80,688		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	temporarily restricted	75,148		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 155,836	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,269,206	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (382,507)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,886,699	$	48

***(See instructions.)**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(98,312)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (98,312)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (98,312)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,338,636	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,338,636	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	13,949	10
11	Nurses Aide Training Reimbursements	49,617	11
12	Gift and Coffee Shop	11,618	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 75,184	23
	D. Non-Operating Revenue		
24	Contributions	152,239	24
25	Interest and Other Investment Income***	827	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 153,066	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	1,213	27
28	management fees	15,587	28
28a	see worksheet 11	2,408	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,208	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,586,094	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	768,992	31
32	Health Care	2,719,943	32
33	General Administration	1,511,755	33
	B. Capital Expense		
34	Ownership	361,330	34
	C. Ancillary Expense		
35	Special Cost Centers	11,694	35
36	Provider Participation Fee	310,692	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,684,406	40
41	**Income before Income Taxes (line 30 minus line 40)****	(98,312)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (98,312)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,112	1,072	23,299	21.73	3
4	Licensed Practical Nurses	16,076	16,073	300,228	18.68	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	3,226	3,226	26,937	8.35	6
7	Licensed Therapist	999	1,030	21,361	20.74	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,439	2,408	32,519	13.50	10
11	Social Service Workers	385	385	9,913	25.75	11
12	Dietician					12
13	Food Service Supervisor	2,109	2,109	32,672	15.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,977	11,982	118,838	9.92	15
16	Dishwashers					16
17	Maintenance Workers	3,086	3,027	42,859	14.16	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,039	1,121	34,328	30.62	20
21	Assistant Administrator	2,028	2,080	37,867	18.21	21
22	Other Administrative	16,252	16,105	211,629	13.14	22
23	Office Manager					23
24	Clerical	4,854	4,875	63,642	13.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	17,554	17,570	278,419	15.85	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	169,097	170,895	1,690,321	9.89	30
31	Medical Records					31
32	Other Health Care(specify)	9,744	9,896	110,614	11.18	32
33	Other(specify) worksheet 2	22,764	22,914	373,393	16.30	33
34	TOTAL (lines 1 - 33)	284,741	286,768	$ 3,408,839 *	$ 11.89	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	257	$ 10,270	1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,210	15	39
40	Physical Therapy Consultant	72	3,035	10a	40
41	Occupational Therapy Consultant	416	20,800	10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	494	19,740	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	48	8,200	15	46
47	Physician & Podiatrist	per visit	18,662	15	47
48	Eye Exams	100	3,000	15	48
49	TOTAL (lines 35 - 48)	1,387	$ 84,917		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	410	$ 19,753	10	50
51	Licensed Practical Nurses	2,407	98,839	10	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,817	$ 118,592		53

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
see worksheet 9			$ 442,363
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 442,363

B. Administrative - Other

Description	Amount
none	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
see worksheet 2		53,230
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 53,230

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,633
Unemployment Compensation Insurance	14,812
FICA Taxes	254,467
Employee Health Insurance	220,784
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan = 65 employees	15,664
Tuition Reimbursement	8,599
Employee Incentives	4,604
Employee Assistance Program	4,161
TOTAL (agree to Schedule V, line 22, col.8)	$ 573,724

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
none		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,424
Health Care Worker Background Check	742
(Indicate # of checks performed 148)	
Recruitment	76
Referral Bonus	160
Physicals	1,742
Publications	2,142
MembershipDues	3,428
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,714

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
none	
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2	none												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,873** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **310,692**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **n/a**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Miller, Cooper & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.